City of Long Beach
Department of Human Resources & Affirmative Action

REASONABLE ACCOMMODATION ASSESSMENT

Please answer each question, and attach all pertinent information explaining your response.

Date _____ Job Analysis Attached ☐ Employee ☐ Applicant ☐

Name _____ Classification _____

Dept/Bureau/Division _____

Name/Title/Phone # of person completing form: _____

1. What action initiated the need for a reasonable accommodation assessment?

   ☐ request by employee/applicant due to physical/mental limitations ☐ results of medical exam ☐ other

2. Can the employee/applicant perform the essential functions without accommodation? ☐ Yes ☐ No

3. What essential functions can the job applicant/employee not perform without an accommodation? List specific duties (example: filing, typing, loading, etc.). Attach sheet if additional space is required.

   _____ _____ _____

   _____ _____ _____

4. Have you met with the employee/applicant to ask him/her how to effectively accommodate his/her limitations? Attach sheet if additional space is required.

Date	Accommodation(s) Requested
_____	_____
_____	_____

5. Have you contacted the Job Accommodation Network (JAN), (800) 232-9675, for suggestions? (maintain names & dates)

   Comments _____

6. Have other applicants with similar limitations been accommodated in the same type of job in question? Please explain.

   _____

7. Please refer to the essential functions listed in #3 above. List and review each essential function separately in the boxes below. Use additional sheets to explain your answer.

   Essential Function: _____

   Have the following items been considered? (please circle). Circle "N/A" if not applicable.

Essential Function: _____	Is it possible to accommodate?		
a. Worksite modification to allow accessibility	Yes	No	N/A
b. Job restructuring	Yes	No	N/A
c. Modified work schedule	Yes	No	N/A
d. Flexible leave policy	Yes	No	N/A
e. Reassignment to vacant position in the same classification within department	Yes	No	N/A
f. Modification of existing equipment or devices	Yes	No	N/A
g. Acquisition of assistive equipment or devices	Yes	No	N/A
h. Assignment of personal assistant, qualified reader or interpreter	Yes	No	N/A
I. Adjustment or modification of training	Yes	No	N/A
j. Assistive equipment or devices owed by employee/applicant	Yes	No	N/A

   k. Other accommodation(s) considered: _____

   Proposed Accommodation: _____

Essential Function: _____

Have the following items been considered? (please circle). Circle "N/A" if not applicable.

	Is it possible to accommodate?		
a. Worksite modification to allow accessibility	Yes	No	N/A
b. Job restructuring	Yes	No	N/A
c. Modified work schedule	Yes	No	N/A
d. Flexible leave policy	Yes	No	N/A
e. Reassignment to vacant position in the same classification within department	Yes	No	N/A
f. Modification of existing equipment or devices	Yes	No	N/A
g. Acquisition of assistive equipment or devices	Yes	No	N/A
h. Assignment of personal assistant, qualified reader or interpreter	Yes	No	N/A
I. Adjustment or modification of training	Yes	No	N/A
j. Assistive equipment or devices owed by employee/applicant	Yes	No	N/A
k. Other accommodation(s) considered: _____			

Proposed Accommodation: _____

Essential Function: _____

Have the following items been considered? (please circle). Circle "N/A" if not applicable.

	Is it possible to accommodate?		
a. Worksite modification to allow accessibility	Yes	No	N/A
b. Job restructuring	Yes	No	N/A
c. Modified work schedule	Yes	No	N/A
d. Flexible leave policy	Yes	No	N/A
e. Reassignment to vacant position in the same classification within department	Yes	No	N/A
f. Modification of existing equipment or devices	Yes	No	N/A
g. Acquisition of assistive equipment or devices	Yes	No	N/A
h. Assignment of personal assistant, qualified reader or interpreter	Yes	No	N/A
I. Adjustment or modification of training	Yes	No	N/A
j. Assistive equipment or devices owed by employee/applicant	Yes	No	N/A
k. Other accommodation(s) considered: _____			

Proposed Accommodation: _____

I certify that the above is a true and correct assessment of providing reasonable accommodation for applicant/employee's job-related restrictions. (sign & date)

_____ _____

Supervisor/Manager completing assessment Department Head or Designee

Concur with assessment: _____

Human Resources/Affirmative Action

Department's meeting with employee/applicant to discuss results of assessment (maintain full documentation in file):

Date: _____ Brief summary of meeting: _____

_____

Date: Brief summary of meeting: